THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

November 25, 2008

Thomas M. McNish, M.D., M.P.H.
Chairman
Advisory Committee on Former
Prisoners of War
3103 Elm Gate
San Antonio, TX 78230

Dear Dr. McNish:

Thank you for the September 22, 2008, report and recommendations of the Advisory Committee on Former Prisoners of War. Our response to the recommendations is enclosed.

Please express my appreciation to all of the members of the Committee for the time and effort they continue to commit to helping us serve former prisoners of war, who sacrificed so much in defending our Nation.

Sincerely yours,

James B. Peake, M.D.

Enclosure

Department of Veterans Affairs Response to
Advisory Committee on Former Prisoners of War (FPOW)
Recommendations

November 2008

Recommendation 1: We recommend the continuation of the Employee Education System FPOW Case Management Conferences for FPOW physicians, clinical support personnel, Veterans Service Representatives, and Rating Veterans Service Representatives.

VA Response: VA agrees with this recommendation to continue the EES FPOW Case Management Conference. Compensation and Pension (C&P) Service will continue to provide subject matter experts to assist in the training sessions at the conference.

Recommendation 2: Refine and Adopt 'Pop-up" Programming in the TURBOVET Program. We strongly encourage the further development and adoption of the TURBOVET program that provides such pop-ups for all compensation and pension (C&P) examinations in general and those for FPOWs in particular as a means to facilitate and standardize the claims process.

VA Response: VA will consider the development of "pop-up" technology, such as that provided by the TURBOVET Program, as an aid to standard C&P examinations. However, the existing Automated Medical Information Exchange (AMIE) worksheet forms include notation on the key items in a C&P exam. Also, the detailed steps of the FPOW examination are addressed in ongoing training for VA clinicians and claims adjudicators.

Cooperation and Crosstalk Between Department of Veterans Affairs (VA) and Department of Defense (DoD) Medical Personnel Still Short of Ideal: As retired or former members of our nation's armed services, we have a keen appreciation of the institutional impediments to inter-departmental communication. However, we also are aware of significant improvement in, for example, the continuity in treatment of TBI patients as they transition from Defense to VA medical facilities. This will hopefully be used to provide template for further enhancements in communication between medical professional in the two departments.

VA and DoD have made significant strides in improving communication and information sharing between the Departments. We share medical records and have consistent, open channels of communication that ensure continuity of treatment for TBI patients. VA expanded its efforts to make patient data more

accessible to clinicians, allied health professionals, and program administrators who need it.

We currently share data in several ways. For example:

- Inpatient and outpatient laboratory and radiology results, allergy data, outpatient pharmacy data, and demographic data on shared patients are viewable by DoD and VA providers through Bidirectional Health Information Exchange (BHIE) from 15 medical centers, 18 hospitals, and 190 clinics managed by DoD, and all VA facilities.

- When a servicemember separates from the military, DoD transmits to VA laboratory results; radiology results; outpatient pharmacy data; allergy information; consult reports; admission, disposition, and transfer information; elements of the standard ambulatory data record; and demographic data.

VA continues to train clinicians to use all existing mechanisms for information sharing to ensure secure and smooth transfer of medical care from DoD to VA facilities.

Recommendation 3: Make Every Effort to Develop Common Language to Document Medical Conditions in Ways that are Responsive to the Administrative Needs of Both Departments. We recommend the education of the medical personnel of both the VA and DoD about the need to properly document medical conditions and their etiologies in the medical record. Focusing on the particular interests of this committee, we believe that these education efforts should underscore the direct connections between the information in the medical record and the disability ratings of the FPOW. Within the context of such training in the VA, we further recommend that such training emphasize the duty to initiate an automatic reconsideration of the disability rating whenever a new, potential service connected diagnosis is made.

VA Response: VA agrees that more can be done to improve communication between VA and DoD through the use of common terminology. A current example of our progress in this area is the collaborative work to establish common terminology for Traumatic Brain Injury. Both Departments are transferring information to support clinical care and the development of benefits claims for these servicemembers. VA's education programs include sessions on military terminology and culture. VA's C&P Service distributes guidance to field offices when a new service-connected presumption is established.

Recommendation 4: Establish Osteopenia/Osteoporosis as a Presumptive Condition for Certain FPOW: We recommend that the Secretary designate Osteopenia/Osteoporosis as a new Presumptive Condition in those FPOWs (and other veterans) who have also been diagnosed with Post Traumatic Stress Disorder (PTSD). The committee is convinced that the scientific data available more than fulfills the standard for establishment as a presumptively combat related disorder.

VA Response: VA has carefully studied the available research on osteopenia and osteoporosis. We are considering these conditions separately in terms of the possibility for service connection. Osteopenia is defined as a decrease in the amount of bone tissue; osteoporosis is defined as premature bone loss which may result in spine, hip or wrist fractures, premature disability, and possible premature death. While in captivity, former prisoners of war were often subject to harsh, debilitating conditions. VA is considering establishing a presumption of service connection for osteoporosis. Comprehensive analysis and ongoing deliberations continue on the issue of establishing a presumption of service connection for osteopenia.

Recommendation 5: Schedule all FPOWs for a baseline bone density screening examination.

VA Response: VA concurs in principle with this recommendation. Bone density examinations should be done when clinically indicated. Most FPOWs of the World War II/ Korean era are of an age when osteopenia or osteoporosis is likely present. If osteoporosis is established as a presumptive disability for service connection, a letter will be sent to FPOWs inviting them to be assessed, and a bone density examination will be part of that assessment.

Recommendation 6: Provide an Annual Report and roster of all personnel responsible for care and treatment of FPOWs. We once again request the annual publication of each Veterans Administration Medical Center's FPOW Coordinator, Physician and other personnel to include contact telephone, email and mailing address. Each time we have asked for this roster in the past, we have found that many facilities are unable to provide such names. This shortfall must be urgently addressed wherever it exists.

VA Response: The VAMC facility FPOW staff list is not an annual publication, but is an internal VA list. We are updating it now and will provide a copy to the committee when it is completed.

Recommendation 7: Initiate Patient Satisfaction Surveys for FPOW C&P Examinations.

VA Response: A Patient Satisfaction Survey will be developed and piloted in one or more VA medical centers with expertise in FPOW C&P examinations to assess the utility/ feasibility of this approach. Initial information on the pilot project should be available by the April 2009 Committee meeting.

Comment: We again underscore the importance of having only properly trained and experienced FPOW Physicians communicate with properly trained and experienced Rating Veteran Service Representatives regarding the performance and rating of FPOW examinations. In this context, properly trained means successfully completing the EES FPOW Case Management Conference. At no time should relatively ignorant providers or raters have responsibility for influencing or making decisions in this relatively unique group of veterans.

VA Response: As stated in our response to recommendation one, VA will continue encouraging participation in the EES FPOW Case Management Conference.

Comment: We are pleased to note the integration of Mental Health Staff/Services into Primary Care Clinics and Compensation and Pension clinical areas in several VAMCs. We recommend the expansion of this concept to all VAMCs.

VA Response: VA has mandated the integration of mental health capabilities into primary care clinics to promote ease of access to mental health services for veterans in an environment that has less risk of the perception of the "stigma" of receiving these services. VA is exploring the need for combined C&P units in its medical centers.

Recommendation 8: The Robert E. Mitchell Center for FPOW Studies: Much Admired, but Not Yet Fully "in the Loop." We once again recommend the establishment of a formal relationship between the Robert E. Mitchell Center (REMC) for Former Prisoners of War and VISN 16.

VA Response: Staff at the Robert E. Mitchell Center, personnel at VISN 16, and local leadership of the new Pensacola Outpatient Clinic are sharing resources and information about health concerns and treatment of FPOWs. VA expects joint VA/REMC collaboration to continue.